STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150037	A. BUILDING _____ B. WING _____	08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK REGIONAL HOSPITAL	801 N STATE ST GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 30405 Facility Number: 005035 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey August 29-31, 2011 Date of ISDH off site review - - February 9, 2012 Reviewer/Surveyor Deborah Franco RN, PHNS Based on review of the August 29-31, 2011 HFAP Accreditation Survey Report, it has been determined that Hancock Regional Hosptial meets the requirements for Hospital Licensure in Indiana.	S 000		